Fachbereich Medizin der
Johann Wolfgang Goethe-Universität
Frankfurt am Main

Immunisation status of visiting students

Family Name:	First Name(s):	Date (dd/mm/yyyy) of birth: / /

A POSITIVE SEROLOGICAL TEST FOR IMMUNITY TO MEASLES, RUBELLA MUMPS AND VARICELLA.

1. Sufficient MEASLES immunity: __________________ (titer) Date: ___/___/___ (day/month/year)
2. Sufficient RUBELLA immunity: __________________ (titer) Date: ___/___/___ (day/month/year)
3. Sufficient MUMPS immunity: __________________ (titer) Date: ___/___/___ (day/month/year)
4. Sufficient VARICELLA immunity: __________________ (titer) Date: ___/___/___ (day/month/year)

TETANUS-DIPHTHERIA-PERTUSSIS BOOSTER (within the last 10 years).

IF TETANUS, DIPHTHERIA AND PERTUSSIS WERE GIVEN SEPARATELY, EACH MUST BE RECORDED.

TDap Booster: ____________ (month/year)

Tetanus: _______________ (month/year)

Diphtheria: _____________ (month/year)

Pertussis: _____________ (month/year)

HEPATITIS B IMMUNIZATION:

Anti HBs-titer: ______________IU/l (at least 100 IU/l required) Date: ___/___/___ (day/month/year)

Serological antibody testing of hepatitis C-virus (HCV)

Result:_________________________ Date: ___/___/___ (day/month/year)

TUBERCULIN SKIN TEST SINCE :

No new skin test required if:

(a) [ ] History of childhood BCG vaccination or (b) [ ] Prior skin test consistent with latent TB

Type and date: _________________________________

PROOF OF CHICKENPOX (VARICELLA) IMMUNITY

A POSITIVE SEROLOGICAL TEST FOR IMMUNITY OR a physician reported medical history data

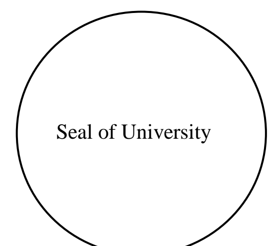
(PLEASE ATTACH REPORT)

HUMAN IMMUNODEFICIENCY SYNDROME (HIV)

Testing not mandatory but highly recommended.

(Student may send Report separately)

Verification by the Dean's Office:



Physician's Signature: ________________________________

Date: ____/____/____ (day/month/year)